Course Description
This course focuses on Nursing care of emotionally ill patients who are experiencing difficulty meeting psychosocial needs. It also focuses on how emotional illness affects the needs of the individual and family in their efforts to adapt to stressors. The physiological and psychological needs of the patient are addressed through Quality and Safety for Nurses (QSEN) Initiative incorporating the concepts of patient centered care, teamwork and collaboration, evidence based practice, safety, quality improvement and informatics; the Nursing Process; and the Categories of Client Needs. Students are also introduced to the principles of management of patient groups.

Class work for a typical week consists of: five (5) hours classroom instruction, one (1) hour weekly college laboratory/simulation, and eight (8) hours of health agency experiences. It is essential for students to engage in additional practice for further development of skills. Provisions are available for additional time in the college laboratory for practice.

STUDENT LEARNING OUTCOMES (SLOs)
The following course SLOs apply when caring for the adult patient and family with common acute and chronic recurrent health alterations in a variety of health care settings. The course SLOs will be achieved by the end of the semester.

Course SLOs

1. Performs safe, caring, patient-centered, evidence-based nursing care to a diverse population of patients and families who are experiencing difficulty meeting psychosocial needs.

2. Applies critical thinking/clinical reasoning strategies when providing nursing care and implementing quality improvement related to patient care.

3. Exhibits teamwork and collaboration with members of the interprofessional team.

4. Interprets informatics principles, techniques and systems when providing nursing care.

5. Explains leadership/management in a variety of healthcare settings for the purpose of providing and improving patient care.

6. Practices professional, ethical and legal principles relevant to the practice of a registered nurse.
ASSESSMENT MEASURES for COURSE SLOs
Students will perform satisfactorily in the classroom, laboratory/simulation and clinical setting as evidenced by achieving 75% or greater on written exams, completion/submission of various course specific written assignments, and demonstration of satisfactory performance on course specific clinical competency and evaluation tools.

ASSESSMENT TECHNOLOGY INSTITUTE (ATI) TESTING
Kingsborough’s Nursing Department uses ATI Nursing Education tutorials, testing and remediation each semester. Active participation in ATI assignments and testing is a requirement of this course and will account for 10% of the course grade. Failure to take the proctored exam as scheduled will result in a grade of incomplete and will prevent progression in the program.

ATTENDANCE
Complete participation in class is possible only when students are able to focus attention on the class; therefore, entering class after it has begun is disrespectful to Faculty and classmates. Talking out of turn or exhibiting other disruptive behaviors is not tolerated and students will be asked to leave the classroom or lab.

All cell phones; smart devices or other multimedia devices that generate sound must be turned off when any member of the academic community enters a classroom. Cellular devices are allowed to be on in the classroom only if the owner is using the caller ID, voice messages or a vibrating battery. NO TEXTING IS ALLOWED AT ANY TIME DURING CLASS AND/OR LABS. Members of the academic community must exit the classroom to make or receive calls.

A student is deemed excessively absent in any course when he or she has been absent 15% of the number of contact hours a class meets during a semester. When a student is excessively absent, a grade of “WU” will be assigned as described in the college catalogue. Attendance at pre and post conference for laboratory experience is required. Absence from either pre or post conference constitutes an absence for the day’s experience.

STUDENTS WITH DISABILITIES
Access-Ability Services (AAS) serves as a liaison and resource to the KCC community regarding disability issues, promotes equal access to all KCC programs and activities, and makes every reasonable effort to provide appropriate accommodations and assistance to students with disabilities. Your instructor will make the accommodations you need once you provide documentation from the Access-Ability office (D-205). Please contact AAS for assistance.

EXAM POLICY
All personal items (backpacks, purses, etc.) must be placed in front of the classroom before the exam begins. The Nursing Department will provide each student with a calculator and #2 pencil during exams. There are to be NO personal items in use (pens, highlighters, pencils, electronic devices, etc.) during an exam. Food and drink is strictly prohibited during the examination period. Students will be asked to remove all hats, scarfs and jewelry prior to the beginning of exams. (The only exceptions are head coverings and jewelry worn for religious purposes). There will be no individual exam reviews with faculty members.

Evaluation
Grades will be calculated according to college and departmental policy as follows:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Points</th>
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<tbody>
<tr>
<td>A+</td>
<td>97 – 100</td>
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<tr>
<td>A</td>
<td>93 – 96</td>
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<tr>
<td>A-</td>
<td>90 – 92</td>
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<td>B+</td>
<td>87 – 89</td>
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<tr>
<td>B</td>
<td>83 – 86</td>
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<tr>
<td>B-</td>
<td>80 – 82</td>
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<tr>
<td>C+</td>
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<td>C</td>
<td>75 – 77</td>
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<tr>
<td>C-</td>
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<td>D+</td>
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<td>D</td>
<td>60 – 65</td>
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<td>F</td>
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(08/06/2014, 8/5/2015, 02/05/16, 1/30/2017, 8/7/17)
W Withdrew without penalty
WU Unofficial withdrawal (counts as failure)
INC Doing passing work, but missing an assignment or an examination; changes to a "FIN" if work is not made up by the 10th week of the next 12-week session
FIN Failure as a result of an Incomplete

Nursing 2000 grades will be calculated as follows:

- Lecture examinations average (2 exams) 55%
- Final examination 35%
- ATI assignments and testing 10%
- Clinical competency Satisfactory or Unsatisfactory
- Unfolding Process Recordings Satisfactory or Unsatisfactory
- Writing assignment Satisfactory or Unsatisfactory
- Case Study Satisfactory or Unsatisfactory

Students are expected to take all exams when scheduled. Exceptions to this rule will be for emergency situations and the faculty must know in advance. Students who do not take an exam on the scheduled date are required to take a makeup exam. All makeup exams may be given at the end of the semester. Students who fail to take the scheduled exams or makeup exams will receive a grade of zero for that test.

All written assignments must comply with college standards for written work. Written assignments are to be turned in during the class period on the date that they are due. All assignments must be handed in by the end of the course, to complete the requirements of the course. A late assignment will meet the requirements of the course but will not receive full credit. If written assignments are not submitted by the end of the course, the student will receive a grade of "INC" for the course. Students must submit all assignments prior to the beginning of the next semester in order to progress in the program.

Clinical agency performance will be evaluated as Satisfactory (S) or Unsatisfactory (U). Performance that has been designated as "U" at the end of the course will result in failure of the course. A minimum average grade of "75%" is required on all clinical assignments to achieve a satisfactory clinical grade.

A conference with the instructor is required at mid-semester, and at the end of the course, at which time the student's progress in the course will be discussed. In addition, students may initiate conferences with the instructor at other times.

RETENTION CRITERIA
Criteria for retention in the Nursing Program mandates that students;

1. Earn a minimum of a "C" grade in every required Nursing and co-requisite course inclusive of BIO 1200, BIO 5100, ENG 2400, and PSY 3200.
2. **Students who achieve a "C-" grade in required clinical nursing course may apply to repeat the course one time only in the semester immediately following, subject to space availability. The minimum grade for clinical courses that are repeated is a "B."** The "Intent to Return to Nursing Course" form can be found on the KCC Website Nursing Department page under "Forms". This must be completed and include a plan of success that demonstrates significant changes in how they will approach the course when repeated. Only one required nursing course may be repeated. A grade of less than a “C” in a second nursing course will cause the student to be dismissed from the program.
3. Students must achieve a grade of "B" in order to pass NUR 1700. Students in NUR 1700 who achieve a failing grade of no less than "C--may repeat the course one time only after submitting an "Intent to Return Form."
4. **Students who enter Nursing 1700 and Nursing 1800 MUST complete the Nursing Program within four years from the date of entry into this course.** Any student who has not attended nursing courses for two or more consecutive semesters cannot be readmitted into the Nursing Program.
unless qualifying examinations have been passed in the required nursing courses previously successfully completed. Qualifying examinations may be repeated only once.
5. Students in the clinical component can only appeal the retention criteria one time.
6. Students in the clinical component can only withdraw once and must be passing to do so

### Teaching Strategies

- Lecture-Discussion
- Role Playing
- Group Work
- Case Studies
- Multimedia
- Computer Assisted Instruction/ATI
- Pre and Post Conferences
- Health Agency Experiences
- Unfolding Process Recording
- Simulated Laboratory Experience
- Reflective Questions

### REQUIRED TEXTBOOKS

**Required Textbooks for Nursing 2000:**

### REQUIRED RESOURCES:
Assessment Technology Institute (ATI).

### PROVIDED REFERENCES:
Nursing Central by Unbound Medicine
- Davis Drug Guide
- Diseases and Disorders
- Taber’s Medical Dictionary
- Davis Lab and Diagnostics Guide

### RECOMMENDED TEXTBOOKS:

### Optional References:

### All students are expected to read and adhere to the policies pertaining to the following, as outlined in the department’s Nursing Student Handbook:

<table>
<thead>
<tr>
<th>Attendance</th>
<th>Netiquette</th>
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<tbody>
<tr>
<td>Malpractice insurance, health clearance, and CPR training</td>
<td>Specific dress requirements for each clinical course</td>
</tr>
<tr>
<td>Evaluation and grading</td>
<td>Drug calculation policy</td>
</tr>
<tr>
<td>Clinical competencies</td>
<td>Mandatory skills review</td>
</tr>
<tr>
<td>College laboratory practice requirements</td>
<td>Criteria for retention in the nursing program</td>
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</tbody>
</table>
Clinical Agency experience requirements

Integrity

Civility (including appropriate dress)

DRESS REQUIREMENTS

Nursing students are representatives of Kingsborough Community College and must present themselves as professional role models.

- All students are expected to observe good personal hygiene. Only non-perfumed products are to be used.
- Students are required to be dressed professionally at all times. No short skirts, low cut tops, tight seductive clothing will be permitted.
- No attire/tinted glasses, which cover the student’s eyes and/or face is permitted.
- The dress code for clinical courses (except Nursing 2000) requires a white uniform (no scrubs) with the Nursing Department patch sewn to the left upper sleeve of the uniform, 2 inches below the shoulder seam. Students must wear white shoes (no sneakers). Uniforms are to be neat, clean, fit appropriately and be in a good state of repair. Head wear for religious reasons should conform with the uniform colors (white).
- Hair is to be clean, neat off the face and above the collar line. Men are to be clean-shaven or have a neatly trimmed beard and/or mustache. No unusual hair color or decorative and pointed hair ornaments/coverage are not permitted. Makeup and hairstyle must be subdued.
- Nails should not extend beyond the fingertips and should be rounded and clean. Only non-chipped nail polish is permitted. Artificial nails of any type are not permitted.
- No jewelry other than a plain wedding ring and/or small stud earring may be worn. No visible body piercing jewelry is permitted.
- A KCC picture ID badge, watch with second hand is required.
- Students must also wear the KCC picture identification badge at all off-campus clinical agency experiences.

Additional Dress Code and Other Requirements for Nursing 2000

Any attire that may negatively impact a patient’s psychopathology is not permitted. (This specifically refers to patients who are paranoid and/or impulsive). Students are expected to dress appropriately in professional attire in the clinical area. Uniforms are not to be worn. The following attire is NOT permitted: Short-skirts, low cut tops, tight, seductive clothing, jeans and tee shirts. Students may not carry cigarettes on the psychiatric clinical units. Additionally, all electronic devices including cellular phones and forbidden on any of the psychiatric clinical unit.

Students who come to the clinical setting improperly attired or unprepared for their assignment will be dismissed by their clinical instructor and counted absent.
Topical Outline

UNIT I
Orientation to Nursing Care of the Emotionally Ill Patient

Unit II
Assessment and Management of a Patient who has a Psychotic Disorder

Unit III
Assessment and Management of a Patient who has a Mood Disorder

UNIT IV
Assessment and Management of a Patient who has a Disorder of Aggression

UNIT V
Assessment and Management of a Patient who has an Anxiety Management Disorder

UNIT VI
Assessment and Management of a Patient who has an Addictive Disorder

UNIT VII
Assessment and Management of a Patient who has an Organic Brain Syndrome
UNIT I – Orientation to Nursing Care of the Emotionally Ill Patient

Content/Lecture Discussion

<table>
<thead>
<tr>
<th>Course Overview</th>
<th>Planning</th>
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</thead>
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<tr>
<td>Review of syllabus</td>
<td>Expected outcome criteria</td>
</tr>
<tr>
<td>Patient assignments</td>
<td>Health promotion activities</td>
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<tr>
<td>Agency policies</td>
<td>Therapeutic interventions</td>
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<td>Pre and post-conferences</td>
<td>Legal/ethical implications of e</td>
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<td>HIPAA</td>
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<tr>
<th>Mental Health</th>
<th>Independent activities</th>
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<tr>
<td>Definition</td>
<td>Coping strategies</td>
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<td>Pathophysiology</td>
<td>Therapeutic communication</td>
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<td>Etiological factors</td>
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<td>o Stress/ defense mechanisms</td>
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<td>o Community management of mental</td>
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<td>illness</td>
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<tr>
<th>Related Factors:</th>
<th>Collaborative activities</th>
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<td>Age</td>
<td>Cognitive therapy</td>
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<td>Genetics</td>
<td>Group</td>
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<td>Milieu</td>
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<td>Trans-cultural considerations</td>
<td>Team concepts</td>
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<td>Crisis intervention</td>
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<td>Family therapy</td>
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<td>Referral/community resources</td>
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<td>Discharge planning</td>
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<td>o Long-term in-patient care</td>
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<td>o Domicillary/ assisted living</td>
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<td>o Case management</td>
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<tr>
<th>Assessment</th>
<th>Evaluation of outcome criteria</th>
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<tr>
<td>Nursing history</td>
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<tr>
<td>Mental Status exam</td>
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<td>Physical assessment</td>
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<td>Psychological Testing</td>
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<td>Developmental assessment: Freud,</td>
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<td>Plaget, and Erickson</td>
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| Revision of plan                     |                                              |

Related Learner Experiences

Required Reading

- Nursing 2000 Syllabus
- Review: PSY 1100 and PSY 3200, NUR 1700, 1800, 2100
- Boyd, Ch. 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16; Appendix A, B

Learner Activities

- Complete developmental worksheet on Blackboard
- Complete defense mechanism worksheet on Blackboard
- Access internet sites on Blackboard
- Answer reflective questions on Blackboard
### UNIT I – Orientation to Nursing Care of the Emotionally Ill Patient

**Clinical Agency Objectives**

The student will:
- Perform a nursing assessment on a psychiatric patient
- Analyze assessment data
- Formulate all relevant nursing diagnoses (minimum 4)
- Prioritize nursing diagnoses
- Formulation plan to achieve patient outcomes
- Implement the plan
- Evaluate patient outcomes
- Communicate & collaborate with the patient, family, and healthcare providers
- Teach patients
- Incorporate national patient safety goals to ensure safe effective care.
**Unit II – Assessment and Management of the Patient who has a Psychotic Disorder**

**Content/Lecture Discussion**

- **Overview**
  - Definition
  - Pathophysiology
  - Etiological factors
  - Classifications
    - Paranoid
    - Disorganized
    - Catatonic
    - Undifferentiated
    - Residual
  - Complications
    - Water intoxication
    - Neuroleptic malignant syndrome
    - Extrapyramidal side effects
    - Agranulocytosis

- **Related Factors**
  - Age
  - Support network
  - GAF/ chronicity
  - Trans-cultural considerations

- **Assessment**
  - Nursing history
  - Mental status exam
    - Positive symptoms
    - Negative symptoms
  - Diagnostic tests/lab tests
    - Neuroanatomical studies
    - Psychological testing

- **Nursing diagnoses**
  - Disturbed thought processes
  - Disturbed sensory perception
  - Decisional conflict
  - Ineffective management of therapeutic regimen
  - Impaired social interaction
  - Impaired verbal communication
  - Disturbed personal identity

- **Planning**
  - Expected outcome criteria
  - Health promotion activities
  - Therapeutic interventions
  - Legal/Ethical implications

- **Implementation – Independent activities**
  - Health promotion

- **Implementation – Collaborative activities**
  - Medications
    - Traditional anti-psychotics
    - Atypical anti-psychotics
    - Anti-cholinergic/anti-Parkinson medications.
  - Procedures/ treatments
    - Acute phase
    - Rehabilitation phase
  - Referrals/community resources
  - Discharge planning
    - Day hospital
    - Case management
    - Long-term placement
    - Domiciliary care
  - Trans-cultural considerations

- **Evaluation of outcomes**

- **Revision of the plan**

**Related Learner Experiences**

**Required Reading**

- Boyd, Ch. 22, 23 And review communication CH.9 Appendix C
- Abrams, Ch. 9 and 12

(08/06/2014, 8/5/2015, 02/05/16, 1/30/2017, 8/7/17)
### Unit II – Assessment and Management of the Patient who has a Psychotic Disorder

#### Learner Activities
- Complete the anti-psychotic medication analysis of side effects on Blackboard
- LWW clinical simulations: Paranoid schizophrenia
- Case study: Paranoid schizophrenia
- Answer reflective questions on Blackboard

#### On-Campus Lab #2 Objectives
The student will
- Perform a mental status exam using CAI
- Identify manifestations of paranoia
- Analyze data from case study and prioritize nursing diagnoses
- Describe measures to detect anti-psychotic medication side effects
- Develop a comprehensive plan of care for a paranoid patient
- Identify teaching strategies for a chronic schizophrenic patient Health Assessment of the Geriatric Patient.

#### Clinical Agency Objectives
The student will
- Perform a nursing assessment on a patient who is psychotic
- Analyze data
- Formulate relevant nursing diagnoses for a psychotic patient (minimum of 4)
- Prioritize nursing diagnoses
- Formulation plan to achieve patient outcomes for a psychotic patient
- Implement the plan
- Evaluate patient outcomes
- Communicate & collaborate with the patient, family, and healthcare providers
- Teach a psychotic patient
  - Preventative health strategies
  - Health maintenance
  - Coping skills
  - Medications
  - Lifestyle modifications
- Incorporate National Patient Safety Goals to ensure safe effect
### Content/Lecture Discussion

#### Overview
- **Definitions**
- **Classification**
  - Unipolar
  - Bipolar
  - Schizoaffective disorder
  - Seasonal affective
  - Dysthymia
- **Pathophysiology**
- **Etiological factors**
  - Genetic
  - Biochemical
  - Psychological
  - Socio-cultural
- **Complications**
  - Suicide
  - Serotonergic syndrome
  - Malignant hypertension
  - Lithium toxicity

#### Factors affecting the development of mood disorders
- **Age**
- **Sex**
- **Culture**
- **Marital status**
- **Social class**
- **Seasonality**

#### Assessment
- **Nursing history**
- **Physical assessment**
- **Diagnostic/Lab tests**
  - Cortisol spit test
  - Serum serotonin and norepinephrine levels
  - Psychological tests self esteem - inventory and projective tests

#### Nursing Diagnoses
- **Risk for violence: self directed**
- **Hopelessness**
- **Powerlessness**
- **Chronic low self-esteem**
- **Social isolation**
- **Risk for suicide**
- **Risk for loneliness**
- **Dysfunctional grieving**
- **Ineffective mgmt. of therapeutic regimen**

#### Planning
- **Expected outcome criteria**
- **Health promotion activities**
- **Therapeutic intervention**
- **Legal/ethical considerations**
- **Cultural considerations**

#### Implementation - Independent Activities
- **Health promotion**
  - Physical/protective needs
  - Interpersonal relationships
  - Cognitive-behavioral therapy
  - Dietary restrictions

#### Implementation - Collaborative Activities
- **Medications**
  - Serotonin reuptake inhibitors (SRIs)
  - Tricyclic antidepressants
  - Atypical antidepressants
  - Monoamine oxidase inhibitors
  - Mood Stabilizers: lithium, anti-convulsants
  - Antipsychotic medications
  - Lithium toxicity
- **Procedures/Treatments**
  - Electroconvulsive therapy
  - Cognitive-behavioral
  - Group therapy
  - Family therapy
- **Discharge planning**
- **Referrals/community resources**

#### Evaluation
- **Evaluation of outcome criteria**
- **Revision of plan**

(08/06/2014, 8/5/2015, 02/05/16, 1/30/2017, 8/7/17)
### Unit III – Assessment and Management of the Patient who has a Mood Disorder

#### Related Learner Experiences

**Required Reading**
- Boyd, Chapter 21, 24,25
- Abrams, Ch. 10
- Dudek, Ch. 18, p. 610, Ch. 5, pp. 127-131

**Videos Shown in Class**
- The Patient with Bi-polar Disorder
- VAMC “Prevention of Suicide”

**Learner Activities**
- LWW Mental Health simulations
  - Suicidal patient
  - Depressed patient
  - Manic patient
- Case studies on Blackboard
  - Major depressive disorder
  - Mania
- Answer reflective questions on Blackboard

**On-campus Lab #3 Objectives**
The student will
- Identify manifestations of depression
- Analyze data from case study and prioritize nursing diagnoses
- Describe measures to detect anti-depressant medication side effects
- Develop a comprehensive plan of care for a depressed patient.
- Describe the use of cognitive therapy for a depressed patient.

**Clinical Agency Objectives**
- Perform a nursing assessment on a patient who has a mood disorder
- Analyze data.
- Formulate all relevant nursing diagnoses.
- Prioritize diagnoses
- Formulate a plan of care to achieve patient outcomes for a patient who has a mood disorder.
- Implement the plan
- Evaluate patient outcomes
- Communicate & collaborate with the patient, family, and health care provider.
- Teach a patient who has a mood disorder
  - Preventive Health strategies
  - Health Maintenance
    - Dietary MAOIs
    - Medication use
    - Lifestyle modifications
- Incorporates National Patient Safety Goals into the plan of care in order to ensure safe effective care delivery
## UNIT IV – Assessment and Management of a Patient who has a Disorder of Aggression

### Content/Lecture Discussion

- **Overview of aggression**
  - Definitions
    - Aggression
    - Hostility
    - Anger
    - Passivity
    - Assertiveness
  - Pathophysiology
  - Etiological factors R/T disorders of aggression
    - Genetic/biochemical
    - Psychological
    - Socio-cultural

- **Classifications:**
  - Personality disorders
    - Borderline
    - Antisocial
    - Schizoid
    - Paranoid
    - Dependent
    - Narcissistic
    - Histrionic
  - Violence
    - Child abuse/neglect
      - Physical
      - Emotional
      - Sexual
    - Domestic violence
    - Elder abuse
    - Rape

- **Complications**
  - Dissociative disorders
  - Borderline disorder

- **Factors affecting the development of aggressive disorders**
  - Age
  - Gender
  - Culture
  - Environment
  - Support network

- **Assessment**
  - Nursing history
  - Physical assessment
  - Diagnostic tests

- **Nursing Diagnoses**
  - Risk for other directed violence
  - Self mutilation
  - Ineffective coping.
  - Rape trauma syndrome
  - Compromised family coping
  - Ineffective sexuality patterns
  - Ineffective role performance

- **Planning**
  - Expected outcome criteria
  - Health promotion activities
  - Therapeutic interventions
  - Legal/ethical considerations
  - Cultural considerations

- **Implementation – Independent activities**
  - Health promotion/teaching
    - Anger management/teaching
    - Behavior modification
    - Support groups
    - Follow-up care

- **Implementation – Collaborative activities**
  - Medications
    - Anti-psychotics
    - Anti-depressants
    - Anti-anxiety needs
  - Procedures/treatments
    - Restraint
    - Seclusion
    - Behavioral management
  - Anger control
  - Referrals/community resources

- **Evaluation**
  - Evaluation of outcome criteria
  - Revision of plan

### Related Learner Experiences

**Required Reading:** Boyd, Chapter 19, 27,28
UNIT IV – Assessment and Management of a Patient who has a Disorder of Aggression

Recommended Resources
- Murphy, Kathryn (2006) Square pegs: Managing Personality Disorders, Nursing Made Incredibly Easy 4 (4) 26-34
- Riley Jane (2007), Do You Know How To Recognize Child Abuse, Nursing Made Incredibly Easy 5 (2) 54-63
- Lynch, SH (1997), Elder Abuse: What to Look For, How to Intervene, 97 (1) 27-33
- www.elderabusecenter.org

Videos Shown in Class
- Child Abuse AJN
- Personality Disorders, World of Abnormal Psychology

Learner Activities
- Borderline patient case study on Blackboard
- Access internet site on Blackboard
- Answer reflective questions on Blackboard

On-Campus lab #4
- The student will
  - Identify manifestations of mania
  - Analyze data from case study and prioritize nursing diagnoses
  - Describe measures to detect mood stabilizer medication side effects
  - Develop a comprehensive plan of care for a manic patient

Clinical Setting
- The student will:
  o Perform a nursing assessment on a patient who has a mood disorder
  o Analyze data
  o Formulate all relevant nursing diagnoses
  o Prioritize diagnoses
  o Formulate a plan of care to achieve patient outcomes for a patient who has a mood disorder.
  o Implement the plan
  o Evaluate patient outcomes
  o Communicate & collaborate with patient, family, and health care provider.
  o Incorporates National Patient Safety Goals into the plan of care in order to ensure safe effective care delivery.
UNIT V – Assessment and Management of a Patient who has an Anxiety Management Disorder

Content/Lecture Discussion

- Content reflective of previously learned knowledge from Psychology 11

- Overview
  - Define anxiety
  - Describe levels/stages of anxiety

- Classifications
  - Generalized anxiety disorder
  - Phobias
  - Obsessive-compulsive disorder
  - Panic disorder
  - Conversion disorder
  - Dissociative disorders
  - Psychosomatic illness
  - Hypochondriasis/somaticization disorders
  - Eating disorders: bulimia, anorexia nervosa

- Etiological factors
  - Genetic/biochemical
  - Psychological
  - Socio-cultural

- Factor affecting the development of an anxiety disorder
  - Age
  - Gender
  - Culture
  - Mental status
  - Support network

- Assessment
  - Nursing history
  - Psychological history
  - Diagnostic evaluations
  - Psychoanalysis
  - Trait characteristics
  - Adversity stimulus

- Nursing Diagnoses
  - Anxiety
  - Fear
  - Defensive coping
  - Post-trauma syndrome
  - Disturbed body image
  - Impaired adjustment
  - Imbalanced nutrition: less than body

- Planning
  - Expected outcome criteria
  - Anxiety management strategies
  - Adaptive coping mechanisms
  - Therapeutic interventions
    - Treatment modalities
      - Medications
      - Cognitive behavioral therapy
      - Systematic desensitization
      - Flooding
      - Relaxation; imagery
      - Behavioral contract
  - Legal/ethical implications of care

- Implementation – Collaborative activities
  - Medications
    - Anxiolytics
    - Benzodiazepines
    - Antidepressants:
  - Psychotherapies
  - Referrals/community resources
  - Discharge planning/community resources
  - Trans-cultural considerations

- Evaluation
  - Evaluation of outcome criteria
  - Revision of plan.
UNIT V – Assessment and Management of a Patient who has an Anxiety Management Disorder

<table>
<thead>
<tr>
<th>Related Learner Experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Required Reading</strong></td>
</tr>
<tr>
<td>• Boyd, Ch. 26,29,30 and 32</td>
</tr>
<tr>
<td>• Abrams, Ch 8</td>
</tr>
<tr>
<td><strong>Recommended Resources</strong></td>
</tr>
<tr>
<td>• Murphy, Kathryn (2005) Anxity: When Is It Too Much, Nursing Made Incredibly Easy 3 (5) 22-33</td>
</tr>
<tr>
<td>• Murphy, Kathryn (2007) The Skinny on Eating Disorders, Nursing Made Incredibly Easy, 5 (3) 40 - 49</td>
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<tr>
<td>• <a href="http://www.adaa.org">www.adaa.org</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Videos Shown in Class</strong></th>
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</thead>
<tbody>
<tr>
<td>• Case study: The Anorexic Patient, on Blackboard</td>
</tr>
<tr>
<td>• Access internet site on Blackboard</td>
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<td>• Answer reflective</td>
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<thead>
<tr>
<th><strong>Learner Activities</strong></th>
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<tbody>
<tr>
<td><strong>On-Campus lab #5</strong></td>
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<tr>
<td>• The student will</td>
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<tr>
<td>‐ Identify manifestations of borderline personality disorder</td>
</tr>
<tr>
<td>‐ Analyze data from case study and prioritize nursing diagnoses</td>
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<tr>
<td>‐ Describe measures to prevent self-mutilation, impulsivity and manipulation</td>
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<tr>
<td>‐ Develop a comprehensive plan of care for a borderline personality disorder patient.</td>
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<td>‐ Describe the use of cognitive therapy with a patient who has borderline personality disorder</td>
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<thead>
<tr>
<th><strong>Clinical Setting</strong></th>
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</thead>
<tbody>
<tr>
<td>• The student will</td>
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<tr>
<td>‐ Perform a nursing assessment on a patient who has anxiety management disorder</td>
</tr>
<tr>
<td>‐ Analyze data</td>
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<tr>
<td>‐ Formulate all relevant nursing diagnoses</td>
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<tr>
<td>‐ Prioritize nursing diagnoses.</td>
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<tr>
<td>‐ Formulate a plan to achieve patient outcomes</td>
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<tr>
<td>‐ Implement the plan</td>
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<tr>
<td>‐ Evaluate patient outcome</td>
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<tr>
<td>‐ Communicate &amp; collaborate with patient, family &amp; health care providers</td>
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<tr>
<td>‐ Teach patients</td>
</tr>
<tr>
<td>‐ Preventive health care strategies</td>
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<tr>
<td>‐ Health maintenance</td>
</tr>
<tr>
<td>‐ Dietary</td>
</tr>
<tr>
<td>‐ Medications</td>
</tr>
<tr>
<td>‐ Lifestyle modifications</td>
</tr>
<tr>
<td>‐ Incorporates National Patient Safety Goals into the plan of care in order to ensure safe effective care delivery.</td>
</tr>
</tbody>
</table>
UNIT VI – Assessment and Management of a Patient who has an Addictive Disorder

Content/Lecture Discussion

- **Overview**
  - Definition
  - Use/abuse addiction,
  - Dependence
  - Tolerance
  - Withdrawal.

- **Classifications**
  - Caffeine
  - Nicotine
  - Alcoholism.
  - Opiates
  - Minor/major tranquilizers
  - Stimulants
  - Cocaine/crack abuse
  - Hallucinogenic abuse
  - Inhalants
  - Marijuana abuse

- **Pathophysiology**

- **Etiological factors**
  - Genetic
  - Biochemical
  - Socio-cultural

- **Complications**
  - Overdose
  - Werniecke-Korsakoff syndrome

- **Factor affecting the development of an addiction disorder**
  - Age
  - Gender
  - Culture
  - Mental status
  - Support network

- **Assessment**
  - Nursing history
  - Physical assessment
  - Behavioral assessment
  - Diagnostic tests
  - Serum levels
  - Urine toxicology
  - Hair analysis
  - Liver function tests

- **Nursing Diagnoses**
  - Ineffective denial
  - Ineffective coping
  - Disturbed sensory perception
  - Altered role performance
  - Diversional activity deficit
  - Chronic low self esteem
  - Dysfunctional family processes: Alcoholism

- **Planning:**
  - Expected outcome criteria
  - Health promotion activities
  - Therapeutic intervention
  - Legal/Ethical considerations
  - Cultural considerations

- **Implementation – Independent activities**
  - Health promotion
    - H.A.L.T.
    - Support Groups

- **Implementation – Collaborative activities**
  - Medication
    - Antagonists (Narcan; anti-lerium)
    - Detoxification protocols
    - Aversion therapy: antabuse, naltrexone
    - Dopamine stimulatios: bromocriptine (parlodel), amantadine (symmetrol)
    - Overdose management
  - Procedure/Treatments
    - Detoxification
    - Recovery groups: counselor-led, peer
  - Discharge Planning
  - Referrals/community referrals

- **Evaluation**
  - Evaluation of outcome criteria
  - Revision of plan
UNIT VI – Assessment and Management of a Patient who has an Addictive Disorder

### Related Learner Experiences

**Required Reading**
- Boyd, Ch.31
- Abrams, Ch. 6, 15, 16

**Recommended Resources**
- Jennings-Ingle, S (2007), The Sobering Facts About Alcohol Withdrawal, Nursing Made Incredibly Easy, 5 (1) 50-60
- www.ncadd.org

**Learner Activities**
- Attend an open 12-step support group and write a reaction paper (outline is on Blackboard)
- Complete substance abuse worksheet on Blackboard
- Access internet site on Blackboard
- Answer reflective questions on Blackboard

**On-Campus lab #6**
- The student will
  - Identify manifestations of anorexia
  - Analyze data from case study and prioritize nursing diagnoses
  - Describe measures to prevent purging by an eating disorder patient
  - Develop a comprehensive plan of care for an anorexic patient.
  - Describe the use of cognitive therapy for an eating disorder patient

**Clinical Setting**
- The student will
  - Perform a nursing assessment on patients with manifestations of anxiety
  - Analyze data
  - Formulate nursing diagnoses related to anxiety disorders
  - Prioritize diagnoses
  - Formulate a plan to achieve patient outcomes
  - Implement the plan
  - Evaluate patient outcomes
  - Communicate and collaborate with patient, family, and health care providers
  - Teach anxiety disorder patients
    - Prevention health strategies
    - Health maintenance
    - Dietary
    - Medication use
    - Lifestyle modifications
  - Incorporates National Patient Safety Goals into the plan of care in order to ensure safe effective care delivery.
UNIT VII – Assessment and Management Mental Health in the older adult.

Content/Lecture Discussion

- **Overview**
  - Definition
    - Mental Health and the older Adult
    - Death and Grief and Loss
    - Cognition,
      - Delirium
      - Dementia
  - Pathophysiology of deliria and dementia
  - Etiological factors:
    - Cerebral atherosclerosis
    - Hormonal imbalances
    - Alcoholism/substance abuse
    - Trauma
    - Infection/fever
    - AIDS
    - MS/Parkinson’s
    - Alzheimer’s
  - Complications
    - Injury
    - Caregivers stress
    - Institutional care
  - Factors related to delirium/dementia
    - Age
    - Genetic/biochemical
    - Psychological
    - Societal attitudes
    - Cultural considerations
  - Assessment
    - Physical
    - Emotional
    - Behavioral
    - Social
    - Cultural

- **Nursing diagnoses**
  - Acute confusion
  - Chronic confusion
  - Impaired memory
  - Impaired environmental interpretation syndrome
  - Caregiver role strain
  - Wandering

- **Planning**
  - Expected outcome criteria
  - Therapeutic interventions
  - Health promotion activities
  - Legal/ethical implications of care

- **Collaborative activities**
  - Procedures/treatments
    - Physical needs
    - Safety needs
      - Structured environment
    - Socialization needs
    - Self-esteem needs
  - Medication therapy
    - Aricept
    - Anti-psychotics
  - Health teaching
    - Physical/protective measures
  - Discharge planning, follow up care
  - Referrals/community resources (support groups, day programs)
  - Trans-cultural considerations

- **Evaluation**
  - Evaluation of outcome criteria
  - Revision of plan

Related Learner Experiences

Required Reading
- Boyd, Chapter 17, 18, 20, 37
- Abrams, pp. 288 – 290

Recommended Readings
UNIT VII – Assessment and Management Mental Health in the older adult.

Learner Activities
- Answer reflective questions on Blackboard

Clinical Setting Objectives #1
- The student will
  - Perform a nursing assessment on patients who have an OBD or OBS; identify capacities and limitations.
  - Analyze data.
  - Formulate nursing diagnoses
  - Prioritize diagnoses
  - Formulate a plan to achieve patient outcomes
  - Implement the plan.
  - Evaluate patient outcomes
  - Communicate and collaborate with patient, family, and healthcare providers
  - Teach patient
  - Preventive health strategies
  - Health maintenance
    o Dietary
    o Medication use
    o Lifestyle modifications

Clinical Setting Objectives #2
- The student will
  - Perform a nursing assessment on a patient who has a substance abuse problem.
  - Analyze data
  - Formulate nursing diagnoses
  - Prioritize diagnoses
  - Formulate a plan of care to achieve patient outcomes.
  - Implement the plan of care
  - Evaluate patient outcomes.
  - Communicate and collaborate with patient, family, and health care procedures.
  - Teach patients
    o Preventive health strategies
    o Health maintenance
    o Dietary
    o Medications
    o Lifestyle modifications
  - Incorporates National Patient Safety Goals into the plan of care in order to ensure safe effective care delivery.